EXHIBIT 2

SCHEDULE A - Renewal Term (Jan 2004 - Dec 2004)

Administrative Services Contract (ASC)

1. Group Name: HI LEX CORPORATION
2. Group Number/Cluster: D501
3. Contract Effective Date: May 01, 1991
4. ASC Funding Arrangement: WEEKLY WIRE
5. Line(s) of Business:

[x] Facility
[ ] Facility Foreign
[ ] Facility Domestic
[x] Physician
[x] Master Medical
[x] Prescription Drugs
[x] Dental
[ ] Vision
[ ] Hearing

*Domestic Facility Code(s): 0

6. Administrative Charge:

	Cost Per Contract	Monthly Contracts	Monthly Premium
A. Base Administration	$35.28	997	$35,174
B. Predetermination-Foot Surgery			
C. Mandatory Second Opinion			
D. Dentemax			
E. Additional Agent Fee			
TOTAL			$35,174

7. Stop-loss Coverage(s):

A. Stop-loss Coverage Purchased

[ ] Standard
[x] Outlier Protection
[ ] None
[x] Specific Only
[ ] Aggregate Only
[ ] Specific and Aggregate

B. Coverage Lines of Business

[x] Facility
[ ] Facility Foreign Payment
[ ] Facility Domestic Charge
[x] Physician
[x] Master Medical
[ ] Prescription Drugs
[ ] All Lines of Business(Aggregate Only)

C. Attachment Point(s) (per contract) Specific: $ 300,000

	Cost Per Contract	Monthly Contracts	Monthly Premium
D. Total Stop-loss Premium	$3.52	997	$3,509

9. Late Payment Charges/Interest:

A. Weekly Late Payment Charge	2%
B. Yearly Statutory Interest Charge (Simple Interest)	12%
C. Provider Contractual Interest	

10. BCBSM Account: Comerica

Wire Number Bank American Bank Assoc

11. Your hospital claims cost reflects certain charges for provider network access, contingency, and other subsidies as appropriate.

BCBSM:

BY: _____ (Signature)

NAME: Michelle R. Napolitan (Print)

TITLE: Rating Analyst II

DATE: 12/10/03

BY: _____ (Signature)

NAME: _____ (Print)

TITLE: _____

DATE: _____

THE GROUP:

BY: _____ (Signature)

NAME: _____ (Print)

TITLE: _____

DATE: _____

BY: _____ (Signature)

NAME: _____ (Print)

TITLE: _____

DATE: _____

SCHEDULE A - Renewal Term (Jan 2005 - Dec 2005)

Administrative Services Contract (ASC)

1. Group Name: HI LEX CORPORATION
2. Group Number/Cluster: D501
3. Contract Effective Date: May 01, 1991
4. ASC Funding Arrangement: WEEKLY WIRE
5. Line(s) of Business:

[x] Facility	[x] Prescription Drugs
[ ] Facility Foreign	[x] Dental
[ ] Facility Domestic	[ ] Vision
[x] Physician	[ ] Hearing
[x] Master Medical	

*Domestic Facility Code(s): 0

6. Administrative Charge:

	Cost Per Contract	Monthly Contracts	Monthly Premium
A. Base Administration	$35.28	1,062	$37,467
B. Predetermination-Foot Surgery			
C. Mandatory Second Opinion			
D. Dentemax			
E. Additional Agent Fee			
TOTAL			$37,467

7. Stop-loss Coverage(s):
   A. Stop-loss Coverage Purchased

[ ] Standard	[x] Specific Only
[x] Outlier Protection	[ ] Aggregate Only
[ ] None	[ ] Specific and Aggregate

   B. Coverage Lines of Business

[x] Facility	[x] Master Medical
[ ] Facility Foreign Payment	[ ] Prescription Drugs
[ ] Facility Domestic Charge	[ ] All Lines of Business(Aggregate Only)
[x] Physician	

   C. Attachment Point(s) (per contract) Specific: $ 300,000

	Cost Per Contract	Monthly Contracts	Monthly Premium
D. Total Stop-loss Premium	$3.93	1,062	$4,174

9. Late Payment Charges/Interest:

A. Weekly Late Payment Charge	2%
B. Yearly Statutory Interest Charge (Simple Interest)	12%
C. Provider Contractual Interest	

10. BCBSM Account: Comerica

Wire Number Bank American Bank Assoc

11. Your hospital claims cost reflects certain charges for provider network access, contingency, and other subsidies as appropriate.

BCBSM:

BY: _____ (Signature)

NAME: Michelle R Magoulian (Print)

TITLE: Rating Analyst II

DATE: 12/21/04

BY: _____ (Signature)

NAME: _____ (Print)

TITLE: _____

DATE: _____

THE GROUP:

BY: _____ (Signature)

NAME: Steven Heeter (Print)

TITLE: Director of HR

DATE: January 6, 2005

BY: _____ (Signature)

NAME: _____ (Print)

TITLE: _____

DATE: _____

SCHEDULE A - Renewal Term (Jan 2006 - Dec 2006)

Administrative Services Contract (ASC)

1. Group Name: HI LEX CORPORATION
2. Group Number/Cluster: D501
3. Contract Effective Date: May 01, 1991
4. ASC Funding Arrangement: WEEKLY WIRE
5. Line(s) of Business:

[x] Facility	[x] Prescription Drugs
[ ] Facility Foreign	[x] Dental
[ ] Facility Domestic	[ ] Vision
[x] Physician	[ ] Hearing
[x] Master Medical	

*Domestic Facility Code(s): 0

6. Administrative Charge:

	Cost Per Contract	Monthly Contracts	Monthly Premium
A. Base Administration	$34.81	1,095	$38,117
B. Predetermination-Foot Surgery			
C. Mandatory Second Opinion			
D. Dentemax			
E. Additional Agent Fee			
TOTAL			$38,117

7. Stop-loss Coverage(s):
   A. Stop-loss Coverage Purchased

[ ] Standard	[x] Specific Only
[x] Outlier Protection	[ ] Aggregate Only
[ ] None	[ ] Specific and Aggregate

   B. Coverage Lines of Business

[x] Facility	[x] Master Medical
[ ] Facility Foreign Payment	[ ] Prescription Drugs
[ ] Facility Domestic Charge	[ ] All Lines of Business(Aggregate Only)
[x] Physician	

   C. Attachment Point(s) (per contract) Specific: $ 300,000

	Cost Per Contract	Monthly Contracts	Monthly Premium
D. Total Stop-loss Premium	$4.05	1,095	$4,435

9. Late Payment Charges/Interest:

A. Weekly Late Payment Charge	2%
B. Yearly Statutory Interest Charge (Simple Interest)	12%
C. Provider Contractual Interest	

10. BCBSM Account: Comerica

Wire Number Bank American Bank Assoc

11. A portion of your hospital savings has been retained by BCBSM to cover costs associated with the establishment, management and maintenance of BCBSM's participating hospital, physician and other health provider networks. The ASC Access Fee also covers any subsidies, surcharges and contributions to reserves ordered by the State Insurance Commissioner as authorized pursuant to P.A. 350.

BCBSM:

BY: _____ (Signature)

NAME: Michelle R. Napolitan (Print)

TITLE: Rating Analyst II

DATE: 9/8/05

BY: _____ (Signature)

NAME: _____ (Print)

TITLE: _____

DATE: _____

THE GROUP:

BY: _____ (Signature)

NAME: _____ (Print)

TITLE: _____

DATE: _____

BY: _____ (Signature)

NAME: _____ (Print)

TITLE: _____

DATE: _____

SCHEDULE A - Renewal Term (Jan 2007 - Dec 2007)

Administrative Services Contract (ASC)

1. Group Name: HI LEX CORPORATION
2. Group Number/Cluster: D501
3. Contract Effective Date: May 01, 1991
4. ASC Funding Arrangement: WEEKLY WIRE
5. Line(s) of Business:

[x] Facility
[ ] Facility Foreign
[ ] Facility Domestic
[x] Physician
[ ] Master Medical
[x] Prescription Drugs
[x] Dental
[ ] Vision
[ ] Hearing

*Domestic Facility Code(s): 0

6. Administrative Charge:

	Cost Per Contract	Monthly Contracts	Monthly Premium
A. Base Administration	$34.35	1,011	$34,728
B. Predetermination-Foot Surgery			
C. Mandatory Second Opinion			
D. Dentemax			
E. Additional Agent Fee			
TOTAL			$34,728

7. Stop-loss Coverage(s):

A. Stop-loss Coverage Purchased

[ ] Standard
[x] Outlier Protection
[ ] None
[x] Specific Only
[ ] Aggregate Only
[ ] Specific and Aggregate

B. Coverage Lines of Business

[x] Facility
[ ] Facility Foreign Payment
[ ] Facility Domestic Charge
[x] Physician
[ ] Master Medical
[ ] Prescription Drugs
[ ] All Lines of Business(Aggregate Only)

C. Attachment Point(s) (per contract) Specific: $ 300,000

	Cost Per Contract	Monthly Contracts	Monthly Premium
D. Total Stop-loss Premium	$5.17	1,011	$5,227

9. Late Payment Charges/Interest:

A. Weekly Late Payment Charge	2%
B. Yearly Statutory Interest Charge (Simple Interest)	12%
C. Provider Contractual Interest	

10. BCBSM Account: Comerica

Wire Number Bank American Bank Assoc

11. A portion of your hospital savings has been retained by BCBSM to cover the ASC Access Fee. The ASC Access Fee covers (a) costs associated with the establishment, management and maintenance of BCBSM's participating hospital, physician and other health provider networks, (b) charges to help maintain BCBSM's surplus at an appropriate level in compliance with regulatory and Blue Cross and Blue Shield Association standards, and (c) cost transfer subsidies or surcharges authorized pursuant to 1980 P.A. 350, such as the group conversion fee and the 'other than group' subsidy.

The Group acknowledges that BCBSM or a Blue Cross and Blue Shield Plan may have compensation arrangements with providers in which the provider is subject to performance or risk-based compensation, including but not limited to withholds, bonuses, incentive payments, provider credits and member management fees. Often the compensation amount is determined after the medical service has been performed and after the Group has been invoiced.

BCBSM:	THE GROUP:
BY: _____ (Signature)	BY: _____ (Signature)
NAME: TERRA L. TURNER (Print)	NAME: _____ (Print)
TITLE: Contracting Analyst II	TITLE: _____
DATE: 8/30/2006	DATE: _____
BY: _____ (Signature)	BY: _____ (Signature)
NAME: _____ (Print)	NAME: _____ (Print)
TITLE: _____	TITLE: _____
DATE: _____	DATE: _____

SCHEDULE A - Renewal Term (Jan 2008 - Dec 2008)

Administrative Services Contract (ASC)

1. Group Name: HI LEX CORPORATION
2. Group Number/Cluster: D501
3. Contract Effective Date: May 01, 1991
4. ASC Funding Arrangement: WEEKLY WIRE
5. Line(s) of Business:

[x] Facility
[ ] Facility Foreign
[ ] Facility Domestic
[x] Physician
[ ] Master Medical
[x] Prescription Drugs
[x] Dental
[ ] Vision
[ ] Hearing

*Domestic Facility Code(s): 0

6. Administrative Charge:

	Cost Per Contract	Monthly Contracts	Monthly Premium
A. Base Administration	$35.03	1,016	$35,590
B. Predetermination-Foot Surgery			
C. Mandatory Second Opinion			
D. Dentemax			
E. Additional Agent Fee			
TOTAL			$35,590

7. Stop-loss Coverage(s):

A. Stop-loss Coverage Purchased

[ ] Standard
[x] Outlier Protection
[ ] None
[x] Specific Only
[ ] Aggregate Only
[ ] Specific and Aggregate

B. Coverage Lines of Business

[x] Facility
[ ] Facility Foreign Payment
[ ] Facility Domestic Charge
[x] Physician
[ ] Master Medical
[ ] Prescription Drugs
[ ] All Lines of Business(Aggregate Only)

C. Attachment Point(s) (per contract) Specific: $ 300,000

	Cost Per Contract	Monthly Contracts	Monthly Premium
D. Total Stop-loss Premium	$8.82	1,016	$8,961

9. Late Payment Charges/Interest:

A. Weekly Late Payment Charge	2%
B. Yearly Statutory Interest Charge (Simple Interest)	12%
C. Provider Contractual Interest	

10. BCBSM Account: Comerica

Wire Number Bank American Bank Assoc

11. A portion of your hospital savings has been retained by BCBSM to cover the ASC Access Fee. The ASC Access Fee covers (a) costs associated with the establishment, management and maintenance of BCBSM's participating hospital, physician and other health provider networks, (b) charges to help maintain BCBSM's surplus at an appropriate level in compliance with regulatory and Blue Cross and Blue Shield Association standards, and (c) cost transfer subsidies or surcharges authorized pursuant to 1980 P.A. 350, such as the group conversion fee and the 'other than group' subsidy.

The Group acknowledges that BCBSM or a Blue Cross and Blue Shield Plan may have compensation arrangements with providers in which the provider is subject to performance or risk-based compensation, including but not limited to withholds, bonuses, incentive payments, provider credits and member management fees. Often the compensation amount is determined after the medical service has been performed and after the Group has been invoiced.

BCBSM:	THE GROUP:
BY: Nicole Staley (Signature)	BY: _____ (Signature)
NAME: NICOLE STALEY (Print)	NAME: _____ (Print)
TITLE: RATING ANALYST I	TITLE: _____
DATE: August 23, 2007	DATE: _____
BY: _____ (Signature)	BY: _____ (Signature)
NAME: _____ (Print)	NAME: _____ (Print)
TITLE: _____	TITLE: _____
DATE: _____	DATE: _____

SCHEDULE A - Renewal Term (Jan 2009 - Dec 2009)

Administrative Services Contract (ASC)

1. Group Name: HI LEX CORPORATION
2. Group Number/Cluster: D501
3. Contract Effective Date: May 01, 1991
4. ASC Funding Arrangement: WEEKLY WIRE
5. Line(s) of Business:

[x] Facility	[x] Prescription Drugs
[ ] Facility Foreign	[x] Dental
[ ] Facility Domestic	[ ] Vision
[x] Physician	[ ] Hearing
[ ] Master Medical	

*Domestic Facility Code(s): 0

6. Administrative Charge:

	Cost Per Contract	Monthly Contracts	Monthly Premium
A. Base Administration	$35.74	1,031	$36,848
B. Additional Agent Fee			
TOTAL			$36,848
C. Administrative Access Fee Cap (Per contract per month)	$35.00		

7. Stop-loss Coverage(s):

A. Stop-loss Coverage Purchased

[x] Standard	[x] Specific Only
[ ] Specific and Aggregate	[ ] Aggregate Only
[ ] None	

B. Coverage Lines of Business

[x] Facility	[ ] Master Medical
[ ] Facility Foreign Payment	[ ] Prescription Drugs
[ ] Facility Domestic Charge	[ ] All Lines of Business(Aggregate Only)
[x] Physician	

C. Attachment Point(s) (per contract) Specific: $ 300,000

	Cost Per Contract	Monthly Contracts	Monthly Premium
D. Total Stop-loss Premium	$9.60	1,031	$9,898

9. Late Payment Charges/Interest:

A. Weekly Late Payment Charge	2%
B. Yearly Statutory Interest Charge (Simple Interest)	12%
C. Provider Contractual Interest	

10. BCBSM Account: Comerica

Wire Number Bank American Bank Assoc

11. If applicable, Group shall pay an Administrative Access Fee ("AAF") which is included in hospital claims cost that is contained in Group's Amounts Billed. The AAF is separate from and does not include BlueCard fees and shall not exceed $35.00 per contract per month. Approximately 120 days after the close of the Contract Year, BCBSM shall report the aggregate amount of AAF actually paid by group.

The Group acknowledges that BCBSM or a Blue Cross and Blue Shield Plan may have compensation arrangements with providers in which the provider is subject to performance or risk-based compensation, including but not limited to withholds, bonuses, incentive payments, provider credits and member management fees. Often the compensation amount is determined after the medical service has been performed and after the Group has been invoiced.

BCBSM:	THE GROUP:
BY: Sandra M Han (Signature)	BY: Jon Fee (Signature)
NAME: Sandra M Han (Print)	NAME: Jon Fee (Print)
TITLE: Regional Sales Manage	TITLE: Secty/Treas
DATE: 1/12/09	DATE: 01/12/09
BY: (Signature)	BY: (Signature)
NAME: (Print)	NAME: (Print)
TITLE:	TITLE:
DATE:	DATE:

SCHEDULE A - Renewal Term (Jan 2010 - Dec 2010)

Administrative Services Contract (ASC)

1. Group Name: HI LEX CORPORATION
2. Group Number/Cluster: D501
3. Contract Effective Date: May 01, 1991
4. ASC Funding Arrangement: WEEKLY WIRE
5. Line(s) of Business:

[x] Facility	[x] Prescription Drugs
[ ] Facility Foreign	[x] Dental
[ ] Facility Domestic	[ ] Vision
[x] Physician	[ ] Hearing
[ ] Master Medical	

*Domestic Facility Code(s): 0

6. Administrative Charge:

	Cost Per Contract	Monthly Contracts	Monthly Premium
A. Base Administration	$36.45	982	$35,794
B. Additional Agent Fee			
TOTAL			$35,794
C. Administrative Access Fee Cap (Per contract per month)	$35.00		

7. Stop-loss Coverage(s):

A. Stop-loss Coverage Purchased

[x] Standard	[x] Specific Only
[ ] Specific and Aggregate	[ ] Aggregate Only
[ ] None	

B. Coverage Lines of Business

[x] Facility	[ ] Master Medical
[ ] Facility Foreign Payment	[ ] Prescription Drugs
[ ] Facility Domestic Charge	[ ] All Lines of Business(Aggregate Only)
[x] Physician	

C. Attachment Point(s) (per contract) Specific: $ 300,000

	Cost Per Contract	Monthly Contracts	Monthly Premium
D. Total Stop-loss Premium	$11.52	982	$11,313

8. Late Payment Charges/Interest:

A. Weekly Late Payment Charge	2%
B. Yearly Statutory Interest Charge (Simple Interest)	12%
C. Provider Contractual Interest	

9. BCBSM Account: Comerica

Wire Number Bank American Bank Assoc

10. If applicable, Group shall pay an Administrative Access Fee ("AAF") which is included in hospital claims cost that is contained in Group's Amounts Billed. The AAF is separate from and does not include BlueCard fees and shall not exceed $35.00 per contract per month. Approximately 120 days after the close of the Contract Year, BCBSM shall report the aggregate amount of AAF actually paid by group.

11. The Group acknowledges that BCBSM or a Blue Cross and Blue Shield Plan may have compensation arrangements with providers in which the provider is subject to performance or risk-based compensation, including but not limited to withholds, bonuses, incentive payments, provider credits and member management fees. Often the compensation amount is determined after the medical service has been performed and after the Group has been invoiced.

BCBSM:

BY: Diane Stout
(Signature)

NAME: Diane Stout
(Print)

TITLE: Account Manager

DATE: 9-29-09

THE GROUP:

BY: J.C. Tao
(Signature)

NAME: John Peck
(Print)

TITLE: Director Finance

DATE: 09/18/09

BY: _____
(Signature)

NAME: _____
(Print)

TITLE: _____

DATE: _____

BY: _____
(Signature)

NAME: _____
(Print)

TITLE: _____

DATE: _____

SCHEDULE A - Renewal Term (Jan 2011 - Dec 2011)

Administrative Services Contract (ASC)

1. Group Name: HI LEX CORPORATION
2. Group Number/Cluster: D501
3. Contract Effective Date: May 01, 1991
4. ASC Funding Arrangement: WEEKLY WIRE
5. Line(s) of Business:

[x] Facility	[x] Prescription Drugs
[ ] Facility Foreign	[x] Dental
[ ] Facility Domestic	[ ] Vision
[x] Physician	[ ] Hearing
[ ] Master Medical	

*Domestic Facility Code(s): 0

6. Administrative Charge:

	Cost Per Contract	Monthly Contracts	Monthly Premium
A. Base Administration	$37.91	876	$33,209
B. Additional Agent Fee			
TOTAL			$33,209
C. Administrative Access Fee Cap (Per contract per month)	$35.00		

7. Stop-loss Coverage(s):
   A. Stop-loss Coverage Purchased

[x] Standard	[x] Specific Only
[ ] Specific and Aggregate	[ ] Aggregate Only
[ ] None	

   B. Coverage Lines of Business

[x] Facility	[ ] Master Medical
[ ] Facility Foreign Payment	[ ] Prescription Drugs
[ ] Facility Domestic Charge	[ ] All Lines of Business(Aggregate Only)
[x] Physician	

   C. Attachment Point(s) (per contract) Specific: $ 300,000

	Cost Per Contract	Monthly Contracts	Monthly Premium
D. Total Stop-loss Premium	$14.60	876	$12,790

8. Late Payment Charges/Interest:

A. Weekly Late Payment Charge	2%
B. Yearly Statutory Interest Charge (Simple Interest)	12%
C. Provider Contractual Interest	

9. BCBSM Account: Comerica

Wire Number Bank American Bank Assoc

10. The Group shall pay an Administrative Access Fee ("AAF") which is included in hospital claims cost that is contained in Group's Amounts Billed. The AAF is separate from and does not include BlueCard fees and shall not exceed $35.00 per contract per month. Approximately 120 days after the close of the Contract Year, BCBSM shall report the aggregate amount of AAF actually paid by group.

11. The Group acknowledges that BCBSM or a Blue Cross and Blue Shield Plan may have compensation arrangements with providers in which the provider is subject to performance or risk-based compensation, including but not limited to withholds, bonuses, incentive payments, provider credits and member management fees. Often the compensation amount is determined after the medical service has been performed and after the Group has been invoiced.

BCBSM:

BY: Diane Stout
(Signature)

NAME: DIANE STOUT
(Print)

TITLE: ACCOUNT MANAGER

DATE: 9-28-10

BY: Steven Lebert
(Signature)

NAME: Steven Lebert
(Print)

TITLE: Underwriter

DATE: 9/28/10

THE GROUP:

BY: Joe Fiat
(Signature)

NAME: Joh Fiat
(Print)

TITLE: Dir. of Finance

DATE: 9/22/10

BY: _____
(Signature)

NAME: _____
(Print)

TITLE: _____

DATE: _____